AUTHORIZAT		, SHARE O			CARE INFORMATION		
Date of Birth:				AKA: SSN:			
Address:							
City/State/Zip Code	1			Phone Number(s):	-3111		
Information to be she	ared or released by:		Informat	ion to be shared or rele	eased to:		
Name:			Name:				
Organization:	7.27		Organiza				
	ontact/address information	in next section.	☐ SMH	 Indicate contact/addr 	ress information in next section.		
Address:	T117 T11117 - 15		Address				
City/State/Zip:	2.85		City/Stat	re/Zip:			
Phone:	T		Phone:	T			
505 29 th Street SE Auburn, WA 98002 253-876-7650 Fax: 253-876-7651	4240 Auburn Way North Auburn, WA 98002 253-876-8900 Fax: 253-876-8980	4238 Auburn Wa Auburn, WA 98 253-876-76 Fax: 253-876-89	002 00	14216 NE 21 st Street Bellevue, WA 98007 425-653-4900 Fax: 425-653-4939	☐ 6100 Southcenter Blvd., Suite 200 Tukwila, WA 98188 206-444-7800 Fax: 206-444-7890		
14270 NE 21 st Street Bellevue, WA 98007 425-653-5000 Fax: 206-726-5790	16225 NE 87 th St.,Suite A-6 Redmond, WA 98052 425-869-4960 Fax: 206-726-5790	11629 Avondale Road Redmond, WA 98052 425-653-5070 Fax: 206-726-5790		8705 166 th Ave NE Redmond, WA 98052 425-869-6634 Fax: 206-726-5790			
1600 East Olive Street Seattle, WA 98122 206-302-2200 Fax: 206-302-2210	122 16 th Ave E Seattle, WA 98112 206-302-2700	9706 4 th Ave NE, Suite Seattle, WA 98115 206-302-2900 Fax: 206-302-2750		2719 East Madison, Suite 200 Seattle, WA 98112 206-302-2600 Fax: 206-726-5769			
OR ☐ This authorization and/or coordinate The person or or ☐ Emergency/ Fa	te care until 30 days afte rganization listed above amily Contact	nge of informat r discharge froi <u>is:</u> Provider □ C	tion betwe m this ep Case Work	een the entities listed isode of care, unless	l above in order to provide revoked by the client.		
The purpose of the ☐ Care Coordinatio Specific Information ☐ Status Report ☐ Information to Coo ☐ Initial Assessment	n to be disclosed: Recent Troprdinate Care Discharge t Medicatio	cility Confirmation reatment/Progress Summary Information Health Information ecords/ IEP	_	al ☐ Other (specify ☐ Other:)		

I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses and health plans/health insurers. HIPAA does not protect the disclosure and possible re-disclosure of personal health information to individuals or organizations not covered by HIPAA. However, other federal and state laws do apply and will continue to protect my personal health information.

This authorization to release or disclose information expires in 90 days unless it is an agreement to share information during this episode of care. My treatment at SMH is not conditioned on signing this authorization. This agreement to request, release or share information may be revoked by me, in writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law.

Client Signature:	Date:	1	/
If Appropriate-			
Parent/Guardian Signature:	Date:	/	/
Relationship to Client Perent Guardian-Appoin	ted Guardian Hoolthoore Power of Attemosy		

Guardian-Other Specify:
References: RCW 70.02, RCW 70.24, RCW 71.05, 42 CFR Part 2, HIPAA

Revised: 02-20-2013

<u>u</u>	Sound Mental	Health	€.	MRN: [**	
AUTHORIZATION to REQUEST			ASE HEALTHO		NEORI	MATION
Cilent Name: (F,M,L)			KA:		0111	WALLON.
Date of Birth:			BSN:			
Address: City/State/Zip Code:			hone Number(s):			
Information to be shared or released by:						
Name:	2.00	Name:	on to be shared or rele	######################################		
Organization: King County Prosecus	toy's office	Organiza	ition: Regional M	entel	Heart	u court
Address: 516 Third Ivenue, WE	n next section.	Address	- Indicate contact/addr	ess Inforr	nation in r	next section.
City/State/Zipi_Seattle. WA GRIDU	-1	City/Stat	BIZIDES CELTICE, W	A 98	24	7
Phone: 206-296-9000		Phone: 2	06-477-6283		*	
505 20th Street SE 4240 Auburn Way North	4238 Auburn Wa	y North	14216 NE 21 st Street	6100 So	uthcenter E	Blvd., Suite 200
Auburn, WA 98002 Auburn, WA 98002 253-876-7650 253-876-8900	Auburn, WA 986 253-876-760		Bellevue, WA 98007 426-853-4900	Tukwita	WA 98188 -444-7600	
Fax: 253-876-7651 Fax: 253-876-8960	Fax; 253-876-89		Fax: 425-853-4939		-444-7890	
14270 NE 21 st Street 16226 NE 87 th St.,Suite A-6	LI 11626 Avondale	Road	8705 186 th Ave NE			
Believue, WA 98007 Redmond, WA 98052 425-553-5000 425-559-4980	Radmond, WA 6 425-653-507	96052	Redmond, WA 98052 425-859-5534			
Fax: 206-726-5790 Fax: 206-726-5790	Fax: 208-728-576		Pax: 205-726-5790			× .
	9706 4 th Ave NE,	Bulte 303	2719 East Madison, Sui	te 200		
Seattle, WA 98122 Seattle, WA 98112 206-302-2200 208-302-2700	Seattle, WA 981 205-302-290		Seattle, WA 95112 206-302-2600			
Fax: 208-302-2210	Fax: 206-302-27		Fax: 206-728-5769	*		
Information to Coordinate Care Initial Assessment Initial Assessment Initial Assessment	nge of information discharge from S. Provider C. S. Confirmation discharge from C. Bummary of Information discharge field information cords/ IEP ement	ion between this epi ase Worke chool-Base Legs Notes	en the entities listed sode of care, uniess ar ed Care Contact	revoked 	order to	provide lient,
I understand that my healthcare information/record contains information about my treatment and services I receive through a variety of programs offered at SMH. This may include information about my mental health, elcohol and drug dependence, STDs and HIV / AIDS status and other specific ereas (i.e., domestic violence) as it applies to my treatment and recovery program. I also understand that my records and healthcare information are protected under both Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law. I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses and health plans/health insurers. HiPAA does						
not protect the disclosure and possible re-disclosure of personal health information to individuals or organizations not covered by HiPAA. However, other federal and state laws do apply and will continue to protect my personal health information. This authorization to release or disclose information expires in 90 days unless it is an agreement to share information during this episode of care. My treatment at SMH is not conditioned on signing this authorization. This agreement to request, release or share information may be revoked by me, in writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law.						
Client Signature:				Date:		
If Appropriate-	-			-u.q.		
Parent/Guardian Signature:				Date:	_/_	1
Relationship to Client: Parent Guardian-A Guardian-Other Specify:	ppointed G	uardian-He	sithcare Power of Attorne	Э У		
References: RCW 70.02, RCW 70.24, RCW 71.05, 42 CFR F	art 2, HIPAA				. Revisi	nd: 02-20-2013

AUTUODIZATION (* BEOUEOT	Sound Mental		MRN:				
Client Name: (F,M,L)	, SHARE O		ASE HEALTHCARE INFORMATIONALE	M			
Date of Birth:			SSN:				
Address: City/State/Zip Code:			Phone Number(s):				
Information to be shared or released by:			on to be shared or released to:	_			
Name:		Name:					
Organization: 2MHC ACA Defens ☐ SMH – Indicate contact/address Information	în next section.	☐ SMH	illon: Regional Meutzu Heastu Cou. - Indicate contact/address information in next section.	lon.			
Address: 110 Preformaine Place S	15tc 200	Address:	516 Third Ave. 5319				
City/State/Zip: Seattle, WA 98100 Phone: 206-624-8105		Phone: 2	206-477-6283	- 100			
505 29th Street SE 4240 Auburn Way North	4236 Auburn Wa		14216 NE 21 st Street . 6100 Southcenter Blvd., Suite	 e 200			
Auburn, WA 98002 Auburn, WA 98002 253-876-7650 253-876-8900	Auburn, WA 98- 253-876-786	00	Bellevue, WA 98007 Tukwila, WA 98188 425-653-4900 206-444-7600				
Fax: 253-876-7691 Fax: 253-876-8980	Fax: 253-878-89	BQ	Fax: 425-653-4939 Fax: 206-444-7890				
14270 NE 21 st Street 16225 NE 87 th 9t.,9uite A-6 Bellevue, WA 98007 Redmond, WA 98052	11629 Avendale Redmond, WA		8705 166 th Ave NE Redmond, WA 98052				
425-653-5000 425-869-4960 Fax: 206-725-5790 Fax: 206-725-5790	426-653-50 Fax: 208-726-57	70	425-959-9634 Fex: 206-726-3790				
1000 East Olive Street 122 16th Ave E	9708 4th Ave NE,		2719 East Madjaon, Suite 200	====			
Seattle, WA 98122 Seattle, WA 98112 206-302-2200 206-302-2700	Sealtie, WA 981 205-302-290	15	Sectile, WA 98112 206-302-2600				
Fax: 208-302-2210	Fax: 206-302-27		Fax: 208-728-5789				
☐ This is a 90 day authorization to reque	st or disclose	healthcai	e Information.				
☑ This authorization allows mutual excha	nge of informat	ion betwe	en the entitles listed above in order to provide	9			
f and/or coordinate care until 30 days afte The person or organization listed above	r discharge froi	n this epi	sode of care, unless revoked by the client.				
☐ Emergency/ Family Contact ☐ Care	Provider C	ase Work	er .				
☑ Care Coordinator ☐ CSO	. □s	chool-Bas	ed Care Contact	-			
The purpose of the request / disclosure is: ☐ Care Coordination ☐ Referral ☐ Disat	ollity Confirmation	n 🗖 Lege	al Other (specify)				
Specific information to be disclosed:	reatment/Progress	•	☐ Other:	_			
	Summary	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		_			
☐ Paychiatrio Evaluation ☐ Physical F	lealth information			_			
Peychological Evaluation School Re Treatment Plan CD Asses	ecords/ IEP						
If Information is requested for specific dates, please note dates:							
I understand that my healthcare information/record contains information about my treatment and services I receive through a variety of programs							
offered at SMH. This may include information about my mental health, alcohol and drug dependence, STDs and HIV / AIDS status and other specific areas (i.e., domestic violence) as it applies to my treatment and recovery program. I also understand that my records and healthcare information are							
protected under both Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law.							
I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses and health plans/health insurers. HIPAA does							
not protect the disclosure and possible re-disclosure of personal health information to individuele or organizations not covered by HIPAA. However, other federal and state laws do apply and will continue to protect my personal health information.							
CONTROL POLICE CONTROL							
This authorization to release or disclose information expires in 90 days unless it is an agreement to share information during this episode of care. My treatment at SMH is not conditioned on signing this authorization. This agreement to request, release or share information may be revoked by me, in							
writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law.							
Client Signature:			Date: / /				
If Appropriate- Parent/Guardian Signature:		23	Date; / /				
Relationship to Cilent: Parent Guardian-A	Appointed	uardian-He	althcare Power of Attorney	-27			
References: RCW 70.02, RCW 70.24, RCW 71.05, 42 CFR			Revised: 02-20-2	2013			

	Sound Mental	Health		MRN:	76		
AUTHORIZATION to REQUEST,			EASE HEALTHO		JEORN	ATION	
Cilent Name: (F,M,L)			AKA:		11 01111	17.11011	
Date of Birth:			ISN:				
Address: City/State/Zip Code:		Ti	hone Number(e):				
Information to be shared or released by:			on to be shared or rel e				
Name:		Name:	on to be anared or ren	easeu to:	170-50		
Organization: Dept. of Public Defe	nse	Organiza	ition: Regional N	erital i	tout	h court	
Address: 516 Third Avenue E-	n next section,	☐ SMH	- Indicate Contact/add	ress Inform	ation in n	ext section.	
City/State/Zip: Seattle, WA 98104		City/Stat	e/ZIp: Seattle.		104		
Phone: 206-296-7662			206-477-621				
L L S05 29 th Street SE 4240 Auburn Way North	4235 Auburn Wa	y North	14216 NE 21 ⁴¹ Street	6100 Sou	thoenter 8	livd., Suite 200	
Auburn, WA 98002 Auburn, WA 98002 253-676-7680 253-976-9900	Auburn, WA 880 253-876-760		Bellevue, WA 95007 425-553-4900	Tukwile, '	WA 98188 444-7800	,	
Fax: 253-676-7651 Fax: 253-876-8980	Fax: 253-876-896		Fax: 425-653-4939	Fax: 206-			
14270 NE 21 st Street 16225 NE 87 th St.,Suite A-8	11629 Avondale	Road	8705 186 th Ave NE				
Bellevue, WA 98007 Redmond, WA 98052 426-653-5000 425-869-4960	Redmond, WA 4 425-553-507		Redmond, WA 98052 425-869-6634				
Fax: 206-726-5790 Fax: 206-728-6790	Fax: 208-726-879		Pax: 206-726-5780				
L. 1600 East Olive Street 122 16 th Ave E	9706 4 th Ave NE,	Sulte 303	2719 East Madison, Su	lte 200			
9eattle, WA 96122 Seattle, WA 96112 206-302-2200 206-302-2700	Sestile, WA 981 206-302-290		Sesttle, WA 98112 206-302-2600			2	
Fex: 208-302-2210	Fax: 206-302-27		Fax: 206-728-5769				
☐ This is a 90 day authorization to reques	t or disclose	healthcar	e information.	5,000			
9R							
This authorization allows mutual exchan	ge of Informati	on betwe	en the entities listed	i evoda in	order to	provide	
and/or coordinate care until 30 days after The person or organization listed above is	aiscnarge tror	n this epi	sode of care, unless	revoked i	by the cl	lent.	
☐ Emergency/ Family Contact ☐ Care F		ase Work	9f				
Care Coordinator CSO		chool-Bas	ed Care Contact		774-4		
The purpose of the request / disclosure is: Care Coordination Referral Disable	litu Cartier star	-	-				
Specific information to be disclosed:	inty Commination	1 1/2 Legs	al 🛗 Other (specify	"			
Status Report Recent Tre	atment/Progrese	Notes [☐ Olher:				
Information to Coordinate Care Discharge Medication	Summary Information		-				
Psychological Evaluation Physical He	ealth Information	•					
Treatment Plan CD Assess							
If information is requested for specific dates, please note dates:							
I understand that my healthcare information/record contain	ne information sho	it my treatn	ent and condess I receive	through a u	arlate of no	1002	
offered at SMH. This may include information about my m	nentel health, elcoh	ol and drug	dependence, STDs and H	HV / AIDS at	o hos suis	ther enerths	
eress (i.e., domestic violence) as it applies to my treatment and recovery program. I also understand that my records and healthcare information are protected under both Federal and State laws and cannot be disclosed or re-disclosed without my consent unless otherwise provided by law.							
I understand that one of the federal privacy laws, the Health Insurance Portability and Accountability Act (HIPAA), has limited applicability and protects the disclosure of information by and between healthcare providers, health information clearinghouses and health plans/neatin insurers. HIPAA does							
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writing, at any time. The revocation will not have any effect on actions taken before the revocation is received by SMH. There may be charges associated with the release of healthcare information. These charges will not exceed the amounts allowable under State law.							
					,		
Client Signature:			16	Date:	/		
Perent/Guardian Signature:				Date:	_/	/	
Relationship to Client: Perent Guardian-Apple	ppointed 🔲 G	uardian-Ha	althcare Power of Attorn				
Guardian-Other Specify: References: RCW 70.02, RCW 70.24, RCW 71.05, 42 CFR P	ert 2, HIPAA		- W		Revise	ad: 02-20-2013	

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION JAIL HEALTH SERVICES

Public Health is not obligated to honor this request unless all portions are completed.

To release the records of: Client Name Client Phone # Alias (Optional) Date of Birth Records will be released to: Person & Institution Affiliation Street Address City/State/Zip Phone Number Fax Number (Optional) Date(s) of services requested: (If no date given: the last incarceration information will be released) For the purpose of: medical/dental legal personal other (describe) Please verify what you are requesting: Release Medical Health Records Understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS) Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization Excludes release of the following information Drug or alcohol abuse diagnosis or treatment HIV (AIDS) testing/treatment Drug or alcohol abuse diagnosis or treatment HIV (AIDS) testing/treatment Drug or alcohol abuse diagnosis or treatment Psychiatric This authorization exprises (insert date or event, invalid if left blank) is the receiver an employer or financial institution? (If yes, this will expire in 90 days) Yes No Client/Guardian Signature Date Relationship to Patient Interpreter Your response to this request within 15 business days. You may revoke this authorization at any time by sending the relative the right to receive your response to this request within 15 business days. You may revoke the authorization at any time by sending the relative the right to receive your response to this request within 15 business days. You may revoke this authorization at least one one of the person under your guerdianship if you do not sign this form. You are entitled to a copy of this form-finance in the subhesiane the subhesiane forms on the subhesiane the recipient and is no longer protected by Public Health Public					
Client Name			or	☐ Jail Health	Records
Client Name					
Client Name	To release the records of	of:			
Person & Institution Affiliation Street Address City/State/Zip Phone Number Fax Number (Optional) Date(s) of services requested: (If no date given: the last incarceration information will be released) For the purpose of: medical/dental legal personal other (describe) Please verify what you are requesting: Release Medical Health Records Other Public Health Medical Records, specify: Verbal Information Exchange: I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization Excludes release of the following information: Drug or alcohol abuse diagnosis or treatment HIV (AIDS) testing/treatment Psychiatric This authorization expires (insert date or event, invalid if left blank) is the receiver an employer or financial institution? (If yes, this will expire in 90 days) Yes No Client/Guardian Signature Date		Client Name		Alias	(Optional)
Street Address Fax Number (Optional)	Records will be release			Date o	of Birth
Phone Number	Person & Institution Affilia	ition			
Date(s) of services requested: (If no date given: the last incarceration information will be released) For the purpose of: medical/dental legal personal other (describe) Please verify what you are requesting: Release Medical Health Records Other Public Health Medical Records, specify: Verbal Information Exchange: I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization Excludes release of the following information: Drug or alcohol abuse diagnosis or treatment HIV (AIDS) testing/treatment Psychiatric This authorization expires (insert date or event, invalid if left blank) is the receiver an employer or financial institution? (If yes, this will expire in 90 days) Yes No Client/Guardian Signature Date	Street Address	T 14 15 15 15 15 15 15 15 15 15 15 15 15 15		City/S	tate/Zip
(If no date given: the last incarceration information will be released) For the purpose of: medical/dental legal personal other (describe)	Phone Number	Fa	x Nu	mber (Optional)	
Please verify what you are requesting: Release Medical Health Records Other Public Health Medical Records, specify: Verbal Information Exchange: I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization Excludes release of the following information: Drug or alcohol abuse diagnosis or treatment	Date(s) of services reque	ested:			0.000 000 00 00 00 00 00 00 00 00 00 00
Please verify what you are requesting: Release Medical Health Records Other Public Health Medical Records, specify: Verbal Information Exchange: I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization Excludes release of the following information: Drug or alcohol abuse diagnosis or treatment Drug or alcohol abuse diagnosis or treatment Psychiatric This authorization expires (insert date or event, invalid if left blank) Is the receiver an employer or financial institution? (If yes, this will expire in 90 days) Client/Guardian Signature Date Relationship to Patient Interpreter Your rights under federal and state law. You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health any not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. You are the treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. You are the streatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. You are the streatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. You are the young the streatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. You are entitled to a copy of this form. You are entitled to a copy of this form. You are entitled to a copy of this form. You are entitled to a copy of this form. You are entitled to a copy of this form. You a	, , ,				•
Release Medical Health Medical Records Other Public Health Medical Records, specify: Verbal Information Exchange: I understand that my records may contain information regarding the testing, diagnosis, and/or treatment of HIV (AIDS Virus), positive sexually transmitted diseases, drug and/or alcohol abuse, mental illness or psychiatric treatment. When checked, this authorization Excludes release of the following information: Drug or alcohol abuse diagnosis or treatment Confirmed STD test results and/or treatment Psychiatric This authorization expires (insert date or event, invalid if left blank) Is the receiver an employer or financial institution? (If yes, this will expire in 90 days) Client/Guardian Signature Date Relationship to Patient Interpreter Your rights under federal and state law. You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health and Interpreted to a copy of this form. You are entitled to a copy of this form when Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES Patient Name: AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES Patient Name: AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES Patient Name: Patient Name: Patient Name: Patient Name: Phone: 206-208-1911 Fax: 206-208-1911 F	For the purpose of: ☐ me	edical/dental 🗌 legal 🔲 pe	ersor	al 🛚 other (des	cribe)
When checked, this authorization Excludes release of the following information: □ Drug or alcohol abuse diagnosis or treatment □ Confirmed STD test results and/or treatment □ Psychiatric This authorization expires (insert date or event, invalid if left blank) is the receiver an employer or financial institution? (If yes, this will expire in 90 days) □ Yes □ No Client/Guardian Signature □ Date Relationship to Patient □ Interpreter Your rights under federal and state law. You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health hay not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. Yhen Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health. Public Health Services Jail Health Services	☐ Release Medical Health ☐ Other Public Health Me	n Records dical Records, specify:		(#)	
□ Drug or alcohol abuse diagnosis or treatment □ Confirmed STD test results and/or treatment □ Psychiatric This authorization expires (insert date or event, invalid if left blank) is the receiver an employer or financial institution? (If yes, this will expire in 90 days) □ Yes □ No Client/Guardian Signature □ Date Relationship to Patient Interpreter Your rights under federal and state law. You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health any not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health. Scattle & King County AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTHINFORMATION - JAIL HEALTH SERVICES Public Health Scattle & King County Interpreter Phone: 206-206-1011 Fax: 206-20	l understand that my records (AIDS Virus), positive sexuall	may contain information regar y transmitted diseases, drug a	ding 1 nd/or	he testing, diagno alcohol abuse, m	osis, and/or treatment of HIV ental illness or psychiatric treatment.
Interpreter Cou have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health has not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health. AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES Public Health Seartle & King County Jail Health Services Jail Health Services Soot Fifth Avenue Seartle, Wa Service Soot Fifth Avenue Seartle, Wa Service Soot Fifth Avenue Seartle, Wa Service Seartle, Wa Service Seartle, Wa Service Seartle, Wa Service Few 206-296-1071 Few 206-296-1071 Few 206-296-1071 Few 206-296-1071 Few 206-205-24109 Few 10-12-12-12-12-12-12-12-12-12-12-12-12-12-	☐Drug or alcohol abuse of	diagnosis or treatment	e of t	☐ HIV (AID	S) testing/treatment
Relationship to Patient Interpreter Your rights under federal and state law. You have the right to receive your response to this request within 15 business days. You may revoke this authorization at any time by sending written revocation. If Public Health has acted on this authorization before receipt of your revocation, we cannot be held liable. Public Health asy not refuse treatment to you or the person under your guardianship if you do not sign this form. You are entitled to a copy of this form. When Public Health discloses this information, it can be subject to re-disclosure by the recipient and is no longer protected by Public Health. AUTHORIZATION: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION - JAIL HEALTH SERVICES Public Health Seattle & King County Patient Name: Jail Health Services Jail Health Services	This authorization expire is the receiver an employe	s (insert date or event, <u>inv</u> r or financial institution? (If y	valid ves, th	if left blank) his will expire in 90	0 days) 🔲 Yes 🔲 No
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